ADVANCED HEALTH CENTER, PC
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Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic - Angel Carrion, DC and /or Lisa Noto-Carrion, DC and/or any other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup Doctor of Chiropractic in this office.

I have had the opportunity to discuss with the treating Doctor of Chiropractic, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ Increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of arterial dissections (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: Will consist of specific Chiropractic Adjustments in addition to any other recommended modality as deemed medically necessary by the treating Chiropractor to include but not limited to Myofascial Release, Ischemic Compression, Extremity adjustments, Basic Exercises for strengthening and stretching of muscles, tendons and ligaments of the spine and extremities, Electrical stimulation, Ultrasound and Laser Therapy. Recommendation may also include nutritional supplements to help maintain a healthy body and orthotics for improved balance, foundational stability and structural correction of the feet and lower kinetic chain.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
Print name

_____
Signature of patient

_____
Date signed

To be completed by the patient's representative:

_____
Print name of patient

_____
Print name of patient's representative

_____
Signature of patient's representative

as:_____
Relationship/authority of patient's representative

_____
Date signed

To be completed by doctor or staff:

_____ _____
Witness to patient's signature Date

_____ _____
Translated by Date